ENROLLMENT

1. **Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).**

_____	SCHIP Medicaid Expansion Program (SEDS form 64.21E)	92,705	Separate Child Health Program (SEDS form 21E)

2. **Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.**

   - As of October 1, 2002, 458,898 children were enrolled for either Medicaid or KidsCare. On October 1, 2001, this figure was 393,176. This information is from monthly enrollment reports generated from PMMIS.

   - The Current Population Survey for the years 1999, 2000, and 2001 shows the rate of uninsured is 197,000 for children under 19 years of age, at or below 200 percent of Poverty; which is a decrease from 311,000.

(States with only a SCHIP Medicaid Expansion Program, please skip to #4)

3. **How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.**

   As of October 1, 2002, 109,456 had been enrolled under Medicaid as a result of having applied for KidsCare then being found eligible for Medicaid. On October 1, 2001, this figure was 77,362. This information is from monthly enrollment reports generated by KEDS.

4. **Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?**

   Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

X	No, skip to the Outreach subsection, below		
_____	Yes, please provide your new baseline	_____	And continue on to question 5

5. **On which source does your State currently base its baseline estimate of uninsured children?**

   _____ The March supplement to the Current Population Survey (CPS)

   _____ A State-specific survey

   _____ A statistically adjusted CPS

   _____ Another appropriate source

   A. **What was the justification for adopting a different methodology?**

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

OUTREACH/ EDUCATIONAL INTERVENTIONS

1. How have you redirected/changed your outreach strategies during the reporting period?

Community Interventions

In the beginning of 2002, the KidsCare Administration had four Regional Outreach Coordinators and a manager to direct statewide outreach activities. Together these coordinators developed an outreach plan which included:

- Supporting and collaborating with the community based organizations on outreach events and in setting up community coalitions,
- Training and education,
- Creating uniform outreach training materials,
- Developing a business packet to target the small business and minority business companies, and
- Working with schools.

The Outreach Coordinators worked closely with coalitions in their communities. These coalitions include grantees, contractors, community organizations and community volunteers. They also supported the promotional events for KidsCare. They regularly attended immunization, health fair and other community events.

The outreach focus changed in the beginning of 2002 because of Arizona's serious budget deficits. The outreach coordinators began directing requests for event participation to community based organizations. The Outreach Coordinators' primary focus changed to training and education. They were also utilized to support the KidsCare office in various functions.

The AHCCCS Community Relations Administrator (CRA) has the responsibility of conducting statewide education. The CRA has also developed a network consisting of community based and other state/county/municipal agencies to assist in maximizing educational efforts. The CRA has also arranged for training of many community based organizations and other groups on KidsCare and the AHCCCS Application for Health Insurance (includes KidsCare program) so that they can, in turn, provide assistance to their clients and communities.

In the future, the CRA's office will have an area on the AHCCCS Website where various forms of information will be posted for advocates/community organizations. Information to be posted includes information packets for new programs, i.e. HIFA waiver parents; an area that provides a comprehensive listing of AHCCCS publications; generated documents, guides, manuals, and reports; community newsletter, AHCCCS program overview and community outreach/education calendar.

2. **What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness? (See also #3)**

Effective Strategies in Community Interventions:

- Certainly, utilization of community based organizations was very successful. Other states that utilize this method also find that their KidsCare numbers increased.

- Training other groups (community based groups, children's groups, providers, community clinics, etc) to conduct outreach and application assistance has proven to be very effective. AHCCCS provides assistance to these groups by answering eligibility questions, following up on applications, and by providing ongoing trainings.

- Collaboration with the City of Phoenix Parks and Recreation after school programs in 121 schools. KidsCare self-screening flyer is distributed to every child that registers for after school program. If the parent notes on the screening form that they want information regarding KidsCare, the City of Phoenix forwards it to the KidsCare office. An application is sent to the family. To date, applications have been mailed.

- Continued mobilization of community coalitions such as community health centers, children's organizations, neighborhood associations, municipal and county programs, city program

- Contractors participate in community health fairs and make available information about their services. They also network with community organizations such as Women, Infants and Children (WIC) offices, Head Start programs, perinatal outreach programs and churches. AHCCCS and its contracted health plans participate in local and statewide partnership activities that remove barriers to services and raise public awareness about the importance of preventive health care. These include The Arizona Partnership for Immunization (TAPI), the Arizona Early Intervention Program (AzEIP), the Governor's Advisory Council on Head Start Collaboration and the Arizona Oral Health Task Force.

- **Contractor Interventions:**

  AHCCCS contracted health plans are also contributing to the KidsCare outreach/education efforts. AHCCCS, in cooperation with contractors and pediatric providers, designed EPSDT tracking forms that have been cited nationally as a "best practice." These forms help guide physicians in providing all the necessary components of a well-child visit at any given time in the child's life, as well as making the necessary referrals for follow-up treatment. A copy of the tracking form, which is completed for each well-child visit, is maintained in the child's medical record and a copy is sent to the child's health plan. This allows the health plan to concurrently track whether children are receiving all the necessary services at the appropriate intervals. Information from the EPSDT tracking forms is entered by each health plan in a database. These forms, which were developed several years ago, continue to be evaluated for possible improvements.

- **Community Organizations:**

Flinn Foundation

Through a grant from the Flinn Foundation, Dr. Jennie Jacobs Kronenfeld, a researcher at Arizona State University (ASU), was charged with assessing ten outreach programs funded through grants from Children's Action Alliance, St. Luke's Charitable Trust, and the Flinn Foundation. The evaluation report covering the funded outreach projects will be completed by 2002. While it is too early to assess final results of the outreach efforts, these grants provide community-based organizations the capacity to provide outreach to families of uninsured children. In addition to the evaluation grant to ASU, the Foundation has awarded KidsCare outreach grants totaling $130,825 to Children's Action Alliance in Phoenix, Interfaith Cooperative Ministries in Phoenix, North Country Community Health Center, Inc. in Flagstaff, Phoenix Day Child and Family Learning Center, Pinal County Division of Public Health in Coolidge, and Yavapai Big Brothers Big Sisters in Prescott. These organizations provided the following outreach activities:

- Information and education on KidsCare eligibility and enrollment through employer-based activities
- Direct assistance to families in the application process
- Follow up activities to assure that all eligibility and enrollment processes are completed.
- Evaluation and assessment of community-based outreach projects (ASU)

In accordance with Foundation policy, grants were time-limited and not subject to renewal.

Children's Action Alliance (CAA)

CAA received $1.2 million from the Robert Wood Johnson Foundation under the Covering Kids and Families project. They now have contracts with five local projects, including El Rio Community Health Center, Phoenix Day School Health Links project, the Yuma County Health Department, Healthy Arizona and Lake Powell Medical Center. The overall goal of the project is to reduce the number of children and adults without health insurance.
Specifically, they are focused on outreach to the community, simplification of the application and enrollment system and coordination between health care programs.

St. Luke's Health Initiatives

The KidsConnect initiative was a three-year program that began in the spring of 1999. The initiative granted a total of $840,213 to Maricopa County East Valley Boys & Girls Clubs, Lake Powell Medical Center which also covers Page and Chapter Houses on the Navajo Reservation, Patagonia School Districts in Patagonia and Santa Cruz County, Phoenix Children's Hospital & Native American Community Health Center, Pima Prevention in Tucson, Scottsdale Prevention Institute, and Valley Interfaith Project for central and western Phoenix.

The goal was to increase the number of children enrolled in Medicaid and KidsCare in order to foster a consistent source of health care. This initiative worked through seven community-based organizations to:

- Identify children not receiving health care who were eligible but not enrolled in AHCCCS or KidsCare;
- Assist parents with the application process and reenrollment; and
- Ensure that the child received health care.

There were a number of lessons learned through these and the other funded outreach efforts. Specifically, there was recognition that virtually many people need personal assistance and that some parents of KidsCare children did not know how to use insurance or the primary health care system. The funding for these projects ended in 2002.

- **Native Americans Interventions**

  From the inception of the KidsCare program, the majority of Native American children were enrolled through the efforts of the Native American Community Health Center and the Phoenix Children's Hospital, through a grant from St. Luke's Charitable Trust, that targeted the state's metropolitan areas. The Indian Health Service (IHS) and tribally operated facilities, however, targeted most Native American communities located in reservation areas statewide.

  IHS and tribal facilities continue their efforts in screening and assisting families with the completion of KidsCare applications. It is important to note that given the high rates of poverty and unemployment in Native American communities, most Native American children have qualified for AHCCCS (Medicaid), through the KidsCare application process. Current enrollment figures show a substantial increase in the number of Native American children enrolled in AHCCCS eligibility categories.

  The Indian Health Service (IHS) is mandated to explore alternate health care resources for Native Americans and within the last year designated full time positions to assisting families in accessing potential benefits, including KidsCare and AHCCCS. These IHS Benefit Coordinators follow up with families by: conducting home visits, assisting potential applicants with verification of income documents, and provide families with a general understanding of KidsCare (and AHCCCS) program requirements.

  Although Native American families receive a one-to-one contact when initially applying for KidsCare, most families still need application assistance when completing annual review applications. Currently, IHS Benefit Coordinators lack a tracking system to know when families' KidsCare cases are due for annual redetermination. However, with the implementation of a web-based member inquiry (at the end of this year), IHS and tribal providers may be able to implement tracking mechanisms to assist families in assuring continued KidsCare eligibility by complying with KidsCare annual reviews.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness? (See also #2)

- AHCCCS and the Department of Education (DOE) partnered to notify families of the KidsCare program through the Child Nutrition Program at the beginning of the school year for the second year in a row. Families complete the simple form, answer three self-screening questions and return it to the school if their child was uninsured, and they wanted an application mailed to them. (Last Year) To date, AHCCCS has received and responded to 18,274 requests for applications from 86 school districts.
- Last year, AHCCCS reported that it was partnering with hospitals in a project to reach the "treat and release" emergency and urgent care patients. Hospitals trained clerical staff to offer the KidsCare flyer to families with uninsured children. The form was then forwarded to an AHCCCS coordinator who contacted the family and provided application assistance. This process was successful for hospitals to receive reimbursement if the child is Medicaid or KidsCare eligible AHCCCS also provided signage and developed the form used to screen patients who may be eligible. However, due to budget constraints, this process was discontinued.
- The KidsCare Outreach Team developed a new brochure explaining the KidsCare program and distributed them to small businesses, medical offices, schools, etc beginning October 1, 2001. The brochure has a postage paid post card attached to it for requesting a KidsCare application. In FFY 2002 approximately 250,000 brochures were distributed. From January 2002 through September 2002 we received 1402 post cards requesting KidsCare applications resulting from this brochure.
- AHCCCS also began partnering with small businesses last year. Due to budget constraints this effort was discontinued. However, a new initiative focusing on small businesses will soon take place in conjunction with St. Luke's Health Initiative and other members of the Health Subcommittee of the Collaboration for a New Century initiative. Further data will be provided on this process in the 2003 report.
- Regional Behavioral Health Authorities/Arizona Department of Health Services Outreach Grant
- Health E Application pilot

- Utilization of community based organization via an outreach grant. Smaller and rural communities respond best to the use of lay health workers or community representatives. Special events are also a draw in rural Arizona. These efforts can be measured by the number of applications completed at the events along with the number of phone call our KidsCare hotline receives.
- The utilization of community based outreach workers has also proven to be very successful. AHCCCS chose to utilize community based organizations as they:
    - Know how to find and engage people requires local knowledge;
    - Have the ability to design and implement outreach strategies at the local level;
    - Know who in the community needs health care; and
    - Offer customized outreach and trusting relationships.
- Training:
    - Training of community health centers staff,
    - Training community advocacy groups regarding assistance to families in the completion of the Universal Application
- Partnerships:

  Municipalities (City of Phoenix - Parks & Recreation and Head Start, City of Glendale);
  Mexican Consulate;
  Community organizations (Big Brother Big Sister Program, fire departments, events in malls);
  Border health initiatives such as Border Fronteriza Project, Arizona Border Health Commission, Western Arizona Health Education Center Promotora Project; and
  Ecumenical groups such as Arizona Ecumenical Council, Catholic Diocese of Phoenix, Southwest Human Development Council; and
  Collaboration with minority health groups – Concilio Latino de Salud; Asian-American Health Outreach Project, African –American Health Committee; and Inter-agency Farmworkers Coalition; Chicanos Por La Causa, Inc.; Friendly House, National Alliance for Hispanic Health, Valle del Sol; Western Area Health Education Center; CAPAZ

- Continue to collaborate with many of the same groups as listed in last year's report:

  Sister State agencies: Department of Health Services; Department of Economic Security, Department of Education
  Organizations: Children's Action Alliance, Flinn Foundation, St. Luke's Health Initiative, City of Phoenix, Community organizations, State health initiatives (Healthy People 2010, Arizona Community Action Association, Arizona Community Council, Community Action Planning Grantees, Health Subcommittee of the Collaboration for a New Century
  Border health initiatives: Border Fronterizas Project, Arizona Border Health Commission, Western Arizona Health Education Center Promotora Project;
  Ecumenical groups (Arizona Ecumenical Council, Catholic Diocese of Phoenix, Southwest Human Development Center) and
  Minority health groups: Concilio Latino de Salud, Asian-American Health Outreach Project, African-American Health Committee, Inter-agency Farmworkers Coalition)

- New collaborations formed include:

  Arizona Homeless Youth Health Coalition, Yuma County KidsCare Coalition, Tucson Volunteer Center, Friendly Access Committee; Homebase Youth Services (homeless teens), Grandparents Raising Grandchildren, Arizona Academy of Pediatrics, Senior Foundation for Living, Scottsdale Prevention Institute, Healthy Childcare Arizona of Central Arizona, Friendly House, Health Cares, Arizona School Nurses Association, White Mountain Apache Tribe

- Native American Outreach/Education

  Successful outreach results occur when our Native American Coordinator, Julia Ysaguirre, is invited to assist in conducting outreach in a community, and the first step is to meet with a tribal leader (tribal chairman, president, or council members) to obtain his/her approval. The tribal leaders then direct staff to proceed with the activities. When staff has been given the authority to conduct outreach activities, they often will think of new ways to make connections with community members. Some staff are influential in recruiting volunteers, other make use of existing community events to implement outreach strategies. Also, community members that are willing to express “success stories” have another way of engaging other potential applicants to complete the application process. For example, if a parent can communicate how KidsCare has helped in the wellness of his/her child, other parents will often follow suit. Another example that continues to help tribal communities understand the importance of applying for KidsCare are tribal behavioral health programs that have had successful outcomes in assisting families to participate in the care and treatment of their children.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All States must complete the following 3 questions

1. **Describe how substitution of coverage is monitored and measured**.

   KidsCare staff screen for other health insurance indicated on the application form. The crowd-out provision for KidsCare states that a child may not have creditable health insurance coverage and may not have had it for a period of three months (until October 1, 2001, six months) prior to enrollment in the KidsCare Program, unless the termination was involuntary or the child is seriously or chronically ill. This information is provided via a monthly denial report indicating reason for denial.

2. **Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?**

   Effective for eligibility beginning October 1, 2001, Arizona Statute reduced the mandatory waiting period following voluntary termination of other creditable health insurance coverage from six months to three months. Because a child may be approved up to three months prospectively if all eligibility requirements are met except for the waiting period, a major impact is that applications are no longer denied due to the waiting period. The waiting period is waived entirely for a seriously or chronically ill child. In FFY 2002, AHCCCS has waived the waiting period for 48 children who were seriously or chronically ill.

3. **At the time of application, what percent of applicants are found to have insurance?**

   In FFY 2002 a total of 2,243 children or 7.25 percent of the total denials have been because the applicant was covered by group or other insurance. This figure does not include those children who were denied because they already had Title XIX coverage.

States with separate child health programs over 200% of FPL must complete question 4

4. **Identify your substitution prevention provisions (waiting periods, etc.).**
   N/A

States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.

5. **Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.**
   N/A

States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. **Identify any exceptions to your waiting period requirement.**

   KidsCare waives the three month period of ineligibility if:
   - The health insurance was provided through an employer and was lost because the employee was fired, laid off, or resigned in lieu of dismissal;
   - The health insurance was Title XXI, Title XIX, or other publicly funded coverage;
   - Someone other than a parent or responsible relative living with the child cancelled the coverage; or
   - The child is seriously or chronically ill.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

   KidsCare does not use the same renewal form as Medicaid; however, the KidsCare renewal form is accepted by Medicaid as an application for the child. If Medicaid recently completed a renewal for XIX, KidsCare uses the information found in Medicaid's computer system to renew eligibility for KidsCare. KidsCare accepts member declaration for income verification and does not require an interview. Medicaid requires verification of income and requires an interview.

2. **Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.**

   A unique partnership has been established between the KidsCare program and the Department of Economic Security (DES) who presently determines the Medicaid eligibility for families and children. If KidsCare screens an applicant potentially eligible for Medicaid, KidsCare refers the application to a special DES unit that forwards the application to a local DES office for processing.

   In addition, if a child loses his/her Medicaid eligibility because of excess income, DES systematically refers an application to KidsCare. If the child is eligible for KidsCare, the KidsCare system automatically approves the child for KidsCare.

3. **Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain**

   Yes. The same delivery system is used for both programs.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply*.

X		**Follow-up by caseworkers/outreach workers**	
X		**Renewal reminder notices to all families, *specify how many notices and when notified***	
		A renewal reminder notice is sent to all members 20 days after the renewal form is sent.	
X		**Targeted mailing to selected populations, *specify population***	Disenrolled members.
X		**Information campaigns**	
X		**Simplification of re-enrollment process, *please describe***	**Reinstate members who have been discontinued for bad debt** (see below).
X		**Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please***	
		Describe	Arizona participated in the NASHP SWOT Team who conducted focus groups.
		Other, *please explain*	

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

The process that AHCCCS has in place to reinstate members who have been discontinued for bad debt has not only assisted us in the retention of our members, but it has also saved us administrative time in processing new applications. Members whose premium payments are over one month overdue are discontinued. If the premium is received after the discontinuance effective date, but prior to the 25th day of the month that the discontinuance was effective, AHCCCS will reinstate the child's eligibility effective the first day of the next prospective month. In FFY 2001 1,475 children were reinstated using this process and 2,217 in FFY 2002.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.

In February 2002, AHCCCS began sending out a survey to parents whose children were disenrolled for preventable reasons. From February to August 2002, 300 surveys per month were mailed out. In September 2002, AHCCCS began sending out 500 surveys per month. Of the 2600 surveys sent out from February through September 2002, 378 have been returned. AHCCCS has collected some valuable information in terms of needing to further educate the parents of our members and discovering that many families self-screen themselves out of the program. AHCCCS will use this information to make further improvements in an attempt to retain our children.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

The survey mentioned in question number three above contains several questions that address premiums. The first question asks the member to select the reason their child is no longer enrolled in KidsCare. One of the options is that they could not pay their premium, 4.9 percent of the respondents chose that answer. Another question asks if the member felt the premium was affordable, 60.4 percent of the respondents answered yes.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

No.

FAMILY COVERAGE PROGRAM UNDER TITLE XXI

1. **Does your State offer family coverage through a family coverage waiver as described in 42 CFR §457.1010?**

   ____ Yes, briefly describe program below and continue on to question 2. **X** No, skip to the Premium Assistance Subsection.

2. **Identify the total State expenditures for family coverage during the reporting period.**

3. **Identify the total number of children and adults covered by family coverage during the reporting period. (Note: If adults are covered incidentally they should not be included in this data.)**

   _____ Number of adults ever enrolled during the reporting period

   _____ Number of children ever enrolled during the reporting period

4. **What do you estimate is the impact of family coverage on enrollment, retention, and access to care of children?**

5. **How do you monitor cost effectiveness of coverage? What have you found?**

PREMIUM ASSISTANCE PROGRAM UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program through SCHIP?
   Note: States with family coverage waivers that use premium assistance should complete the Family Coverage Program subsection. States that do not have a family coverage waiver and that offer premium assistance, as part of the approved SCHIP State Plan should complete this subsection and not the previous subsection.

   ____ Yes, briefly describe your program below and continue on to question 2. **X** No, skip to Section IV.

2. **What benefit package does your state use? e.g., benchmark, benchmark equivalent, or secretary approved**

3. **Does your state provide wrap-around coverage for benefits?**

4. **Identify the total number of children and adults enrolled in your premium assistance SCHIP program during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).**

   _____ Number of adults ever enrolled during the reporting period

   _____ Number of children ever enrolled during the reporting period

5. **Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program.**

6. **Indicate the effect of your premium assistance program on access to coverage.**

7. **What do you estimate is the impact of premium assistance on enrollment and retention of children?**